STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) NAME OF PROVIDER OR SUPPLIER:		· · · · · · · · · · · · · · · · · · ·		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 03/01/2023	
SUSQUEHANNA VALLEY SURGERY CENTER, L.L.C. STATE LICENSE NUMBER: 11761500			4310 LONDONDERRY ROAD, SUITE 1 HARRISBURG, PA 17109				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	CORRECTIVE ACTION SHOULD BE COMPLI		(X5) COMPLETE DATE
S 0000	This report is the relicensure survey co 2023, at Susquehan Center. It was dete was in compliance of the Pennsylvania Health's Rules and Ambulatory Care F Title 28, Part IV, St Chapters 551-573, I	y cy nents	S 0000				
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	

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Certified End Page

SUSQUEHANNA VALLEY SURGERY CENTER, L.L.C.

STATE LICENSE NUMBER: 11761500 SURVEY EXIT DATE: 03/01/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY